Enrollment Form for Men & Women 50+

Nebraska Colon Cancer Screening Program

DHHS Nebraska Department of Health and Human Services

1. **ALL SHADED QUESTIONS MUST BE ANSWERED. Please print. Fill in as much as possible.**
2. **Read and Sign the back of this page.**
3. **Return this form to the Nebraska Colon Cancer Screening Program.**

Version August 2008

First Name	Initial	**Last Name**	Maiden Name *(if applicable)*

Birthdate month / day / year	Age	Gender M / F	Social Security #

Address	**City**	County	**State**	**Zip**

Home/Cell Phone *circle one* ( )

Work Phone ( )

How did you hear about the program?
❑Doctor ❑Other healthcare provider ❑Family ❑Friends
❑Radio ❑Television ❑Magazine ❑Newspaper
❑Billboard ❑Website ❑Mailing/Flyer ❑EWMProgram
❑Community Event ❑Other_____

Contact person: _____
(in case we can't reach you)
Relationship:_____ Phone: (___)_____
Address:_____
City:_____State:_____ Zip:_____

Are you of Hispanic/Latina/Latino origin?
❑Yes ❑No
Country of origin _____
What is your primary language?
❑English ❑Spanish
❑Vietnamese ❑Other_____

What race or ethnicity are you?
❑American Indian Tribe _____
❑Black/African American ❑Mexican American
❑White ❑Asian
❑Pacific Islander
❑ Other _____

Highest grade in school you completed: *circle one*
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

I will be required to show proof that my income is within the NCP income guidelines when I am contacted by the NCP staff.
If I am found to be over the income guidelines, I will be responsible for my bills.

What is your household income before taxes?
Yearly Income: $

How many people live on this income?

Do you have:
❑Medicare Part A and B **❑Medicare Part A only**
❑Medicaid (full coverage for self) **❑None/No Coverage**
❑Private Insurance with or without Medicaid Supplement *(please list)*
_____

Is your insurance an HMO? ❑Yes ❑No *An HMO is a health maintenance organization.*

Family History:

How many 1st degree relatives, excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have colon cancer or rectal cancer?
❑0 ❑1 ❑2 ❑3+ ❑Don't Know
How many of those family members with colon cancer were under the age of 60?
❑0 ❑1 ❑2 ❑3+ ❑Don't Know

How many 1st degree relatives, excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have polyps in the colon?
❑0 ❑1 ❑2 ❑3+ ❑Don't Know
How many of those family members with polyps were under the age of 50?
❑0 ❑1 ❑2 ❑3+ ❑Don't Know

How many 1st degree relatives, excluding yourself, ***(parents, brothers, sisters, children)*** have been told they have other types of cancer?
❑0 ❑1 ❑2 ❑3+ ❑Don't Know
What kind of cancer did they have?
_____

Personal History:
Have you ever had any of the following tests?:

Fecal Occult Blood Test (FOBT)
❑Yes ❑No ❑Don't Know Date __/__/__
What did your doctor say about your exam?
_____
Was your exam: ❑Positive ❑Negative

Colonoscopy ❑Yes ❑No ❑Don't Know Date __/__/__
What did your doctor say about your exam?
_____
Were there polyps removed? ❑Yes ❑No ❑Don't Know

Sigmoidoscopy
❑Yes ❑No ❑Don't Know Date __/__/__
What did your doctor say about your exam?
_____
Were there polyps removed? ❑Yes ❑No ❑Don't Know

Double Contrast Barium Enema (DCBE)
❑Yes ❑No ❑Don't Know Date __/__/__
What did your doctor say about your exam?
_____

MUST COMPLETE AND SIGN BACK ☞☞☞☞

Mailing Address: Nebraska Colon Cancer Screening Program -301 Centennial Mall South, P.O. Box 94817-Lincoln, NE 68509-4817

Nebraska Colon Cancer Screening Program Enrollment Form (continued)

Personal History: ***(continued)***

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Crohns Disease	❑Yes	❑No	❑Don't Know
Familial Adenomatous Polyposis (FAP)	❑Yes	❑No	❑Don't Know
Hereditary Non Polyposis Colorectal Cancer (HNPCC)	❑Yes	❑No	❑Don't Know
Inflammatory Bowel Disease (IBD)	❑Yes	❑No	❑Don't Know
Ulcerative Colitis	❑Yes	❑No	❑Don't Know

Are you currently under a doctor's care for any of the above conditions? ❑Yes ❑No ❑Don't Know

Within the last **30 days** have you had bleeding from the rectum? ❑Yes ❑No ❑Don't Know
What did your doctor say about your rectal bleeding? _____

Have you ever been told that you have had polyps in the colon? ❑Yes ❑No ❑Don't Know
What type of polyps did you have? _____
How many polyps did you have? _____

Have you ever been told you have had colon or rectal cancer? ❑Yes ❑No ❑Don't Know
If yes, when were you diagnosed? _____/_____/_____

Please tell us who your primary healthcare provider is (name of doctor): _____

Name of clinic: _____ City: _____ Phone: _____

Informed Consent and Release of Medical Information

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must be 50 years of age or older and fall within the income guidelines in order to be eligible for enrollment. I also understand that I need to complete an enrollment form every year in order to participate in the NCP.
- If I am under 50 years of age, I know I **cannot** be a part of the NCP (***there are no exceptions***).
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to NCP, I will not get reminders about screening.
- Based upon my health history and what type of test is best for me, I know that the NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT from the program and have a positive test, it may be followed up with a colonoscopy.
  - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost to the NCP.
  - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I have talked with my healthcare provider about how I am going to pay for any tests or services that are not paid by the NCP.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My healthcare provider, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal screening, diagnostic tests, and/or treatment services to the NCP.
- To assist me in making the best healthcare decisions, NCP may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- I understand that I need to identify a primary healthcare provider on my form. The NCP may follow up with my primary healthcare provider if my past medical records need to be reviewed to determine the best colon cancer screening for me. I accept responsibility for following through on any advice my healthcare provider may give me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

_____

Signature Date of Signature

_____

Please Print Name Date of Birth